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## Abstract

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# Somatic versus sympathetic mediated chronic limb pain. Experience and treatment options.

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## Author information

### Abstract

It has been helpful in our practice to separate somatic from sympathetic-mediated peripheral nerve pain. We would recommend application of the new nomenclature of type I complex regional pain (sympathetic dystrophy) and type II complex regional pain (causalgia) (see Table 1). We believe it is essential that both of these conditions be separated into their early and late phases and that the treatment alternatives be customized for the individual patient and the peripheral nerve involved. If a cast, pin, or external fixation apparatus is associated with peripheral nerve pain, the offending apparatus must be removed immediately and other forms of treatment initiated for the underlying injury. For acute injury and postsurgical pain, narcotic pain medications should be used no longer than 72 hours and careful patient re-examination must be performed if pain persists. Prescription of narcotic pain medications on a continuing basis is often the primary reason for the development of chronic pain syndromes. Physical therapy for the patient with chronic peripheral limb pain must be performed in a pain-free environment. "No pain, no gain" does not apply in the treatment of chronic limb pain-rather the reverse: "Only gain with no pain." In differentiating between sympathetic pain and somatic pain, the use of the reflex sympathetic dystrophy (RSD) score can be helpful (Table 4). If the pain is somatic, treatment options include: Somatic Pain: Treatment Isolated nerve block Continuous nerve block TENS (external) Direct electrical nerve stimulation (internal) Nerve ablation If the pain is sympathetic in origin, treatments to be considered are: Sympathetic Nerve Pain: Treatment Protection of limb (garment or splint) Combine with active use Sympathetic blocks single continuous Sympathectomy In addition, the treatment of each of those conditions must be directed at the primary condition. Once the two conditions are separated, a careful program of pain management is required. In patients who present with late pain dysfunction, the more commonly observed phenomenon at our institution, the combination of physician, surgeon, and anesthesiologist is essential. The role of physical therapist in restoring function to the injured limb must be discussed and planned carefully. Initial pain management is organized through a qualified anesthesiologist dedicated to this field. Physical therapy follows but only in a pain-free environment. The surgeon's role is to assist and direct the pain management program. Surgeons can be involved in the placement of percutaneous catheters, as well as isolated peripheral nerve blocks. Surgical intervention is limited to the release of compressive neuropathies, nerve transfers, and revascularization of the peripheral nerve bed. The surgeon occasionally may be involved in the

manipulation and pinning of contracted joints, as well as release of muscle or joint contractures, followed by a supervised program of early range of motion. Finally, it is important that both physician and surgeon serve as patient advocates when questions of workers' compensation intervene that could deter proper treatment programs or when the patient needs the encouragement and guidance to continue with treatments that don't always initially appear to have immediate results. Finally, requests to the surgeon to find an operative cure must be resisted while continued psychological encouragement is provided.

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